Harrisburg Human Relations Commission
Use only

Docket No. _____
EEOC No. _____
Social Security No. _____

HRC can investigate complaints of discrimination based upon race, color, religion, ancestry, age (40-70), sex, national origin, place of birth, marital status, familial status, non-job related handicap or disability, known association with a handicapped or disabled individual, a GED certificate, sexual preference/orientation.

IN-17 FORM NON-JOB RELATED HANDICAP/DISABILITY QUESTIONANAIRE

Questionnaire on the incident you are complaining about.

Rev.-10-01

To avoid rewriting your answers, please read this short questionnaire from beginning to end before filling out your answers to individual questions. Please answer every applicable question as fully as possible, and to the best of your present knowledge, information and belief. If you are unsure of your answer, please say so. It is your responsibility to notify this Agency of a change of address or times of unavailability. Failure to notify this Agency may result in dismissal of the matter.

Name _____

Address _____

City _____ State _____Zip Code _____

County _____ Telephone No. H ( ) _____ W ( ) _____

May we call you at work? Yes _____ No _____

Caution: Failure to correctly identify the name of the legal entity you are complaining about will hinder the processing of your complaint. Bring pay stubs, W-2 forms, contracts, etc. to aid in verification of the name and address.

Name of Organization your complaint is against:

Name _____

Address _____

City _____State _____Zip Code_____

Type of Business _____

County _____Telephone No. _____

Number of employees who work at the organization named above. Please check one.

Less than 4 _____ 15 to 100 _____ 201 to 500 _____ Unknown _____

4 to 14 _____ 101 to 200 _____ 501 plus _____

Name and address of person who will now how to contact you and who does not reside in your home.

Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone No. H ( ) _____ W ( ) _____

In this Questionnaire, you will see the word "class" mentioned. **Class means the person's race, sex, age, ancestry, religion and so on**. Depending on the issues in the complaint, you may belong to two or more classes. For example, a Black female could belong to two classes: race/Black and sex/female. A White male could belong to race/White and sex/male. All persons named in the complaint or questionnaire should be identified by their class ask follows: John Doe (White male), John Doe (under age 40), Jane Doe (Black female). For example, if your complaint is based on race, include the race of all persons mentioned. If it is a sex complaint, mention the sex of all persons mentioned.

1. Discrimination means difference of treatment. Please explain what happened to you and why you feel you were treated differently. In other words, what happened to persons of a different class that makes you feel they received more favorable treatment than you did.

   _____
   _____
   _____
   _____
   _____

2. If you believe the organization treated you this way because of one or more of the reasons listed below, please check those reasons. If you believe the employer treated you this way for a reason which is not listed, explain what you believe to be the reason.

___ Sex	___ Ancestry	___ Age (40-70) ___ Date of Birth
___ Race	___ National Origin	___ Use of guide dog or support animal
___ Color	___ GED	___ Sexual preference/Orientation
___ Religious Creed	___ Retaliation	
___ Place of Birth	___ Marital Status	___ Non-job related handicap/disability
___ Familial Status		identify your disability _____

   _____

3. Describe your disability. Provide the medical name for your disability, if known, as well as a general description of your disability in non-medical terms. Describe in general what major life activities (such as walking or lifting) are affected by your disability and describe the extent to which that activity is affected.

   _____
   _____
   _____
   _____
   _____
   _____
   _____

4. Is your disability permanent:

Yes _____ No _____

Or temporary?

Yes _____ No _____

5. How long is your condition expected to last?

_____

When was your disability first diagnosed? Date _____

Was it caused by injury or accident?

Injury _____ Accident _____

Date this injury/accident occurred? _____

Is your disability improving?

Yes _____ No _____

Is your disability worsening?

Yes _____ No _____

6. If your disability was caused by or made worse by a job-related injury or accident, did you apply for workers compensation?

Yes _____ No _____

6a. If yes, were you awarded workers compensation?

Yes _____ No _____

6b. For what period of time were you on workers compensation?

Years _____ Months _____ Days _____

6c. If you are still on workers compensation (or were on workers compensation at the time of the alleged discrimination), explain how you would be able to perform the essential functions of your regular job with or without an accommodation while still on workers compensation.

_____

_____

_____

_____

7. Describe the job in question and explain how your particular disability affects your ability to perform this job.

_____
_____
_____
_____
_____

7a. Describe any limitations or restrictions related to this job which have been placed on you by a physician for reasons related to your disability.

_____
_____
_____
_____
_____

7b. If your physician recommended that you be placed on "light duty" what type of light duty assignments were recommended and for what period of time?

_____
_____
_____
_____
_____

7c. Does the Respondent (your employer) have a light duty program?

Yes _____ No _____

7d. If so, is this duty limited in any way (e.g., only to persons who had on-the-job injuries, for a limited period of time, for certain categories of employees only, etc.)

_____
_____
_____

8. Have you received any rehabilitation, in the form of specialized training to perform a job similar to the position in question?

Yes ___ No ___

If yes, describe the nature of this training.

_____
_____

9. Describe how, when and which Respondent management officials became aware of your disability and any job-related limitations or restrictions caused by that disability.

_____
_____
_____
_____

10. Have any Respondent managers or supervisors made negative comments concerning your disability?

Yes _____ No _____

If so, provide the name and title of each person making the comments and describe those comments in terms of what was said, when it was said and whether there were any witnesses to those statements.

Name _____ CLASS _____

Title/Dept. _____

Describe comments made _____
_____
_____
_____

Who witnessed this?

Name/Title _____

Name/Title _____

Name/Title _____

11. Do you (or did you) need a reasonable accommodation in order to perform the job in question?

Yes _____ No _____ If yes, please describe the accommodation made. _____

_____
_____

11a. If yes, describe for what part or parts of the job you required an accommodation.

_____
_____

11b. Indicate how frequently this part of the job is done and the importance of this part of the job to the total job.

_____
_____

12. Are you (or were you) able to perform all parts of the job in question other than the part(s) described above for which you require an accommodation?

Yes _____ No _____

What were the major functions you were able to perform without an accommodation?

_____
_____
_____

13. What types of physical activity are difficult or impossible for you to perform?

____ Visual ____ Bending _____ Dexterity _____ Standing for long periods

____ Hearing ____ Stooping _____ Running _____ Sitting for long periods

____ Walking ____ Turning _____ Swallowing ____ Perform manual tasks

____ Lifting _____ Climbing _____ Other** ____ Caring for yourself

If Other**, please explain. _____

Please provide copies of any medical information, certifications, etc., regarding your handicap/disability.

14. Do you have any restrictions on mental activities?

Yes _____ No _____

If yes, please explain. _____
_____
_____

14a. Please provide names and addresses of doctors, hospitals, counselors, organizations, etc. who may be able to provide data concerning your handicap/disability and the extent of any treatment or specialized training you have had or are receiving.

Name/Title _____

Address _____

Treatment/Training _____
_____
_____

Name/Title _____

Address _____

Treatment/Training _____
_____
_____

Name/Title _____

Address _____

Treatment/Training _____
_____
_____

14b. Please provide specific dates and reasons, for each occasion in the last two years, you have been admitted to any hospital/medical facility.

Date _____ Reason _____

_____

Date_____

_____

Date _____

_____

Date _____

_____

14c. Are you currently taking any prescribed drugs related to your handicap/disability?

Yes _____ No _____

If yes, please specify the name of the drug(s), the dosage taken and the name of the prescribing physician.

Drug _____ Dosage Taken _____

Prescribing Physician _____

Drug _____ Dosage Taken _____

Prescribing Physician _____

14d. Are you currently receiving medical treatment of any king?

Yes _____ No _____

If so, name the doctor/hospital, how often the treatment is given and is it given during the day or evening hours.

Doctor/Hospital _____

How Often _____ Day or Evening _____

Doctor/Hospital _____

How Often _____ Day or Evening _____

14e. If you receive such treatment(s), is it during potential working hours?

Yes _____ No _____

How long are the treatment visits?

_____

Can the hours be changed as not to conflict with employment?

Yes _____ No _____

How often are the treatment visits:

_____

What is the effect of the treatment or of any medication that may be taken during this treatment?

_____

Was the Respondent aware of this?

Yes _____ No _____

If yes, under what circumstances, and what comments were made at that time?

_____
_____

15. Did you request a reasonable accommodation?

Yes _____ No _____

15a. When did the employer become aware of the certification that you could perform the job with or without reasonable accommodation?"

_____

15b. From whom did you request a reasonable accommodation?

Name/Title _____

Please provide a copy of the written request, if you have one.

15c. Was any cost attached to this reasonable accommodation?

Yes _____ No _____

If yes, approximately how much would these accommodations cost, including special equipment, building renovations and work force changes?

_____

_____

16. Did the Respondent refuse the request for a reasonable accommodation?

Yes _____ No _____

If yes, who refused it, when was it refused and what reason was given for the refusal?

Name/Title _____

Date _____

Reason _____

_____

17. Did the Respondent offer another or different accommodation?

Yes _____ No _____

If yes, what was the accommodation offered?

_____

_____

Did you and/or your doctor refuse this offer?

Yes _____ No _____

If yes, why?

_____

_____

18. Did the Respondent inquire either orally or on its application about <u>past</u> handicap/disability, <u>current</u> handicap/disability <u>of both</u>?

Yes _____ No _____

If yes, which?

Orally _____ Application _____ Both _____

19. What specific inquiries were made and what were your responses to each?

Inquiry _____

Response _____

Inquiry _____

Response _____

20. If the Respondent inquired about current handicap/disability, did the Respondent inquire beyond the mere existence of such handicap/disability to determine the extent to which it might interfere with your ability to perform the job responsibilities?

Yes _____ No _____

21. Was there any discussion of accommodations that might be made to enable you to perform the job responsibilities?

Yes _____ No _____

If yes, please explain.

_____

_____

22. Have you ever been employed in a position requiring substantially the same duties or responsibilities as the position in question?

Yes _____ No _____

If yes, please describe the job duties.

When, Date _____

Employer _____

Job Title/Dept. _____

Duties _____

Was the Respondent aware of this?

_____

Yes _____ No _____

If yes, what was the Respondent's Comments?

_____

_____

_____

23. When you were employed in the past, what restrictions were placed on your job responsibilities because of your handicap/disability?

_____

_____

Do you feel that this was justified?

Yes _____ No _____

Who placed these restrictions on your job responsibilities?

You _____ Your Doctor _____ Your Employer _____ Your Employer's Doctor _____

24. Do you have a physician, health service or rehabilitation clinic that has/will certify that you can perform the job in question with or without reasonable accommodation?

Yes _____ No _____

If yes, please give names and address.

Name/Title _____

Address _____

Name/Title _____

Address _____

25. If you are claiming that you are not disables, but Respondent incorrectly "perceived" you to have a disability, describe what disability you are perceived as having.

_____

25a. Indicate which Respondent representative(s), by name and job title, perceive you to have this disability and what makes you believe that those persons have this perception.

Name/Title _____

Reason _____

_____

Name/Title _____

Reason _____

_____

26. If the Respondent has taken an action against you because you are viewed as being a "direct threat" (i.e., that because of your disability you posed a threat to your own safety or the safety of co-workers), provide the name and title of the Respondent representative who informed you of this.

Name/Title _____

26a. When did this occur? _____

26b. Was this done verbally or in writing? _____

26c. What reason(s) was given for considering you a direct threat? _____

_____

26d. Was a reasonable accommodation offered?

Yes _____ No _____

27. Does the employer require employees to undergo pre-employment medical examinations?

Yes _____ No ___

28. Did the Respondent in any manner, or based on past practices, indicate that any other factors were involved in the decision to deny, limit or withhold employment, such as age, race, national origin, etc?

Yes _____ No _____

If yes, please explain _____

_____

29. A Medical Release Form is enclosed for your signature. Please read the form before signing. If you do not sign the Medical Release Form, please explain why.

_____

_____

_____

If there are other facts you feel should be considered, record these on the last page of the questionnaire (Continuation Page).

I hereby verify that the statements contained in this complaint are true and correct to the best of my knowledge, information and belief. I understand that false statements herein are made subject to the penalties of 18 PA.C.S. Section 4904, relating to unsworn falsification to authorities.

_____

Signature Date

_____

Address

_____( )_____

City, State and Zip Code Telephone Number

CONTINUATION PAGE

For use if additional pages are needed to answer any question(s). Indicate the question number that is being answered before each response below.